

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150088	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2013
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NAME OF PROVIDER OR SUPPLIER ST VINCENT ANDERSON REGIONAL HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2015 JACKSON ST ANDERSON, IN 46016
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S000000	The visit was for investigation of a State hospital complaint. Complaint Number: IN 00129225 Substantiated: Deficiencies cited related to the allegations. Survey Date: 6-20-13 and 6-21-13 Facility Number: 005078 Surveyor: Brian Montgomery, RN Public Health Nurse Surveyor QA: cloughlin 08/14/13	S000000		
S000930	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based upon document review, observation and interview, the registered nurse failed to ensure that the fall risk policy was followed for patients determined to be at risk for falls for 3 of 7 (patients 25, 26 and 27) medical	S000930	9/11/13 Involved nurse no longer employed by St. Vincent Anderson Regional Hospital. 9/11/13 Nursing associate provided education via the monthly Inpatient Nursing Director newsletter (to be distributed by 9/30/13) on the	09/30/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>records (MR) reviewed.</p> <p>Findings:</p> <p>1. The policy/procedure Keep Our Patients Safe -Falls Prevention (approved 5-09 and revised 5-13) indicated the following: "Assess risk for falls upon admission and then every shift ...using the KOPS assessment toolImplement appropriate KOPS Interventions ...Score of 5 through 10 - document score on Patient Care Flow Sheet and implement ...yellow dot on door and chart ...yellow arm band ...sign in room ...yellow slippers ..."</p> <p>2. The MR for patient 27 indicated an initial fall risk score of 7 on 10-01-10 at 1714 hours and indicated that fall prevention interventions including yellow fall prevention slippers were initiated for patient 27 and the MR entry dated 10-22-10 at 1010 hours indicated that yellow slippers were in use at the time of the fall risk assessment.</p> <p>3. The MR entries related to patient 27's fall on 10-22-10 at approximately 2155 hours indicated that the patient was assisted up to the bathroom by a nurse and indicated that the patient was not wearing yellow slippers. The MR lacked documentation to indicate the fall</p>		<p>need to document in the medical record any time a patient refuses to comply with a hospital policy. 9/30/13 To insure compliance with placement of fall risk indicators the Inpatient Nursing Director will have an associate package: two yellow dots (for placement on the door frame and on the outside of the medical record), yellow arm band and yellow slippers. Packaged items will be retrieved when a patient is determined to be at risk of falling. A daily monitor will be completed on all new admissions to determine, if fall risk indicators are in place, for patients determined to be at risk of falling. 9/2013 SEED Learning Module (web based training program) developed by Inpatient Nursing Educators related to "Keep Our Patients Safe –Falls Prevention Program". Learning module assigned to all inpatient nursing staff for completion annually. Title of person responsible for follow up: Director, Inpatient Nursing</p>				

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S000932	<p>risk patient refused to comply with the facility requirement to wear the yellow non-slip footwear.</p> <p>4. During a tour of the 6 South nursing unit on 6-20-13 at 1250 hours, the following deficient practices were observed: the door frame (6123) for a patient (P26) identified as a risk for falls lacked an fall risk indicator and the MR chart for a patient (P25) identified as a risk for falls lacked a fall risk indicator in accordance with facility policy.</p> <p>5. During an interview on 6-20-13 at 1250 hours, staff A5 confirmed that patients 25 and 26 were a fall risk and confirmed that room 6123 (patient 26) lacked a fall risk indicator on the door frame and that the MR chart for patient 25 lacked a fall risk indicator in accordance with the Fall Prevention policy.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based upon document review and</p>	S000932	9/2013 SEED Learning Module	09/11/2013

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	<p>interview, the nursing staff failed to document a fall risk care plan in response to an assessed need for 5 of 7 (patients 21, 23, 25, 26 and 27) medical records (MR) reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The Keep Our Patients Safe - Falls Prevention Program (approved 9-09) indicated the following: " Explain the KOPS (Keep Our Patients Safe) program to patient and/or significant others when fall risk is identified ...Incorporate " Risk for Falls " into the patient ' s plan of care and document goals, interventions and patient ' s response in the patient progress record ... " The policy/procedure indicated that a patient was at risk for falls based on a fall risk score of 5 or greater and indicated a list of appropriate interventions to implement for at risk patients. 2. The MR for patient ' s 21 and 23 indicated that the patients were at risk for falls based on a fall risk score of 5 or greater and indicated that fall risk interventions were initiated for the 2 patients. The MR for patient ' s 21and 23 lacked a Risk for Falls care plan. 3. The MR for patient ' s 25 and 26 		<p>(web based training program) developed by Inpatient Nursing Educators related to "Keep Our Patients Safe –Falls Prevention Program". Learning module addresses need for fall risk care plan for patient identified to be at risk. Learning module assigned to all inpatient nursing staff for completion annually. 9/11/13 Monthly nursing chart review by assigned Practice Facilitator to include review of 5 charts of patients identified to be at risk of falls and validate that falls risk and appropriate safety interventions included on the patient care plan. Completed chart reviews to be reviewed by unit manager and provide feedback to staff nurse as needed. Oversight of entire chart review assigned to Director of Inpatient Nursing. 9/11/13 Unit managers to incorporate into daily rounds validation of "yellow sticker", indicating at high risk of falls, on chart and door frame of patients identified as at risk of falling. Title of person responsible for follow up: Director, Inpatient Nursing</p>		

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	<p>indicated a fall risk score of 5 or greater on admission for each patient, a need for a Risk for Falls care plan was not identified on admission for either patient, and both patients experienced a fall during the hospital stay.</p> <p>4. The Health Admission History for patient 27 dated 10-01-10 at 1714 hours indicated that a Risk for Fall care plan was needed for patient 27 on admission. The MR failed to indicate that a Risk for Fall care plan was initiated until 10-23-10 after the patient had experienced a fall on 10-22-10.</p> <p>5. On 6-21-13 at 0910 hours, staff A1 and A2 confirmed that the MR for patient 27 indicated a need for a Risk for Falls care plan was identified on the day of admission and no Risk for Falls care plan was included in the plan of care for patient 27 until after the patient had fallen.</p>				